Children's Special Health Services (CSHS) Application

Families requesting financial help for special medical care from Children's Special Health Services (CSHS) must complete both sides of this application. This information will be used to determine eligibility and allow release of information to appropriate caregivers. It will be kept strictly confidential. Please provide all the requested information.

IN ORDER TO COMPLETE YOUR APPLICATION IN A TIMELY MANNER, PLEASE SUBMIT THE FOLLOWING:

1) Copies of two months current paycheck stubs of all persons living in the household for income verification.
2) If self-employed attach a copy of your current year 1040 tax form and profit and loss schedule, (if income shows on line 7 of 1040 we need verification).
3) Current physician notes regarding medical condition.
4) Signed and completed application.
5) If requesting coverage for medication, please provide name of pharmacy _____

Patient's Name _____ Date of Birth _____
Social Security No. _____ Gender _____ Race _____
Home Phone _____ Message Phone _____
Mailing Address _____ County of Residence _____
City _____ State _____ Zip _____
E-mail Address _____ _____

Applicant's Medical Concern(s) _____

Physician _____ Phone Number _____
Address _____
City _____ State _____ Zip _____

Specialist _____ Phone Number _____
Address _____
City _____ State _____ Zip _____

Dentist _____ Phone Number _____
Address _____
City _____ State _____ Zip _____

Orthodontist _____ Phone Number _____
Address _____
City _____ State _____ Zip _____

Father _____ Date of Birth _____ Social Security No. _____
Address if different than above _____
City _____ State _____ Zip _____
Father's Employer _____ Work Number _____

Mother _____ Date of Birth _____ Social Security No. _____
Address if different than above _____
City _____ State _____ Zip _____
Mother's Employer _____ Work Number _____

Legal Guardian if different than above _____
Address _____ Phone Number _____
City _____ State _____ Zip _____

Please list the names and dates of birth of all persons living in the home ↓

NAME	Date of Birth

NAME	Date of Birth

Release of Information:
I certify that the information I have given is true to the best of my knowledge. I give permission to the State of Montana to make any necessary contacts to check my statements. I agree all providers can release any medical, social and insurance information about my child to CSHS upon request in order to administer CSHS benefits. Once information is provided to CSHS, I hold the provider harmless for subsequent disclosures of this information by CSHS. If I knowingly give false information to enroll my child in CSHS, I understand that I must reimburse the State of Montana for any costs incurred, and benefits from CSHS will terminate. This release is effective for 18 months from date signed.
Revocation Statement: I understand I have the right to revoke the above authorization for the release of information at any time by contacting CSHS in writing. Children's Special Health Services, PO Box 202951, Helena MT 59620.

_____ _____
Signature (Parent or Legal Guardian) ***Date***

MONTANA
Department of Public Health & Human Services

Children's Special Health Services (CSHS) Application

List income from all sources. Income includes but is not limited to wages, tips, social security income, unemployment income, retirement income, AFDC, child support payments received, alimony, strike benefits, interest and dividends, disability benefits, workers' compensation, veteran's payments, and Bureau of Indian Affairs payments. If there is no family income, write "NONE" and initial. Indicate how often you receive the amounts listed.

NOTE: Attach a copy of wage check stubs or other financial documentation to verify your claim. If self-employed, report business income from your most recent income tax return, profit and loss schedule and send a copy. **ALL REPORTED INCOME MUST BE DOCUMENTED** or your application process will be delayed.

Gross income means before any deductions on income taxes, social security, insurance premiums, etc.

Employee	List all Sources of Income For Household	Wages Every Two Weeks	Wages Twice Monthly	Wages Monthly	Total Gross Yearly Income

Is the child you are applying for a U.S. citizen? ☐ **Yes** ☐ **No**

Do you care for children, disabled or elderly adults while you and your spouse are working? Please supply verification.

Person(s) receiving care	Name of person giving care	Amount paid	How often do you pay

Have you applied for **Medicaid** for this child? ☐ Yes ☐ No If Yes, Pending (date filed) _____

If the child has Medicaid, list card number here: _____

Medicaid Eligibility dates: ***From*** _____ ***To*** _____

If the child has been denied Medicaid, please attach a copy of the Medicaid Denial

HEALTH INSURANCE INFORMATION*: *Please attach a copy of your insurance card(s).

Does your family have Health Insurance? ☐ Yes ☐ No _____

***SUBSCRIBER – CARD HOLDER INFORMATION*:**

Subscriber (Name) _____ Subscriber (Date of Birth) _____

Subscriber (Social Security Number) _____

Subscriber (Employer) _____ City/State Employed In _____

***INSURANCE COMPANY INFORMATION*:**

Insurance Company (Name) _____

Address where claims are sent _____

City _____ State _____ Zip _____

Insurance Company (Phone Number) _____

Policy Number on Card _____ Eligibility Start Date _____

Group Number on Card _____ Eligibility End Date _____

Your Yearly Deductible? _____ Copay? _____

Your out of pocket monthly Health Insurance cost? _____ Maximum out of pocket (stop loss)? _____

Is the patient's condition covered by insurance? ☐ Yes ☐ No _____

If No, what condition(s) are not covered? _____

Does your insurance cover Prescriptions? ☐ Yes ☐ No _____

***DENTAL INSURANCE*:**

Does your child have Dental Insurance? ☐ Yes ☐ No _____

Does your insurance cover Orthodontics for your child? ☐ Yes ☐ No _____

The Department of Public Health and Human Services (DPHHS) does not discriminate on the basis of race, color, religion, creed, political ideas, sex, age, marital status, physical or mental disability, or national origin. If you believe you have been subjected to discrimination, contact the DPHHS Human Resources Division at 406.444.3136 or the Montana Human Rights Bureau at 800.542.0807, or relay service at 711.

RETURN THIS APPLICATION TO:

Children's Special Health Services, PO Box 202951, Helena MT 59620-2951
(406) 444-3622 (local) or (800) 762-9891 (in state)
Fax: (406) 444-2750

MONTANA
Department of Public Health & Human Services

Please fill this page out if you have additional Health Dental Insurance or Comments

***HEALTH INSURANCE INFORMATION*: Please attach a copy of your insurance card(s).**

Does your family have Health Insurance? ☐ Yes ☐ No _____

***SUBSCRIBER – CARD HOLDER INFORMATION*:**

Subscriber (Name) _____ Subscriber (Date of Birth) _____

Subscriber (Social Security Number) _____

Subscriber (Employer) _____ City/State Employed In _____

***INSURANCE COMPANY INFORMATION*:**

Insurance Company (Name) _____

Address where claims are sent _____

City _____ State _____ Zip _____

Insurance Company (Phone Number) _____

Policy Number on Card _____ Eligibility Start Date _____

Group Number on Card _____ Eligibility End Date _____

Your Yearly Deductible? _____ Copay? _____

Your out of pocket monthly Health Insurance cost? _____ Maximum out of pocket (stop loss)? _____

Is the patient's condition covered by insurance? ☐ Yes ☐ No _____

If No, what condition(s) are not covered? _____

Does your insurance cover Prescriptions? ☐ Yes ☐ No _____

***DENTAL INSURANCE*:**

Does your child have Dental Insurance? ☐ Yes ☐ No _____

Does your insurance cover Orthodontics for your child? ☐ Yes ☐ No _____

RETURN THIS APPLICATION TO:

Children's Special Health Services, PO Box 202951, Helena MT 59620-2951
(406) 444-3622 (local) or (800) 762-9891 (in state)
Fax: (406) 444-2750

MONTANA
Department of Public Health & Human Services